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C) The adjusted direct medical education cost per diem as calculated in Section A.2.a.iii.B) above shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.

D) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in Sections A.2.a.iii.B) or A.2.a.iii.C) above, whichever is less.

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==07/95 b. Calculation for subsequent rate periods

==07/95 i. For the rate period described in Section B.2.a. of Chapter XVI., the final rate per diem shall be determined by taking the operating, capital, and direct medical education trended rate cost per diems calculated under Section A.2.a. of this Chapter and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section B.2.a. of Chapter XVI.

==07/95 ii. For rate periods beginning on or after April 1, 1994, as described in Section B.2.b. of Chapter XVI., the final rate per diem for a hospital described in Section B. of Chapter VI. shall be determined by:

10/93 A) Adding the operating and capital trended rate cost per diems calculated under Sections A.2.a.i. and A.2.a.ii. of this Chapter that were in effect on June 30, 1993;

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==07/95 B) Updating the trended rate cost per diems described in Section A.2.b.ii.A) above:

==07/95 1) In the case of a hospital described in Section C.7. of Chapter II., by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section B.2.b. of Chapter XVI.; and

==07/95 2) In the case of a hospital described in Section C.1., C.2., or C.4., of Chapter II., or for a hospital unit described in Sections D.1. and D.2. of Chapter II., to the midpoint of the current rate period described in Section B.2.b. of Chapter XVI., by utilizing the TEFRA price inflation factor.

==07/95 c. Rebasing

==07/95 For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using the methodology set forth in Section A.2.a. of this Chapter for the calculation of operating and capital trended rate cost per diems using base period cost reports, as described in Section B.1. of Chapter XVI.

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10/93 B. Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals

10/93 1. Calculation of Alternate Cost Per Diem Rates for All Hospitals

==07/95 For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section A.2. of this Chapter, derived from the provider's base period cost reports, as described in Section B.1. of Chapter XVI.

10/93 2. Calculation of Payment Rates for Certain Exempt Hospital Units

==07/95 a. For admissions occurring within the rate period described in Section B.2.a. of Chaper XVI.:

10/93 i. In the case of a distinct part unit, as described in Section D. of Chapter II., the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period.

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10/93 ii. The resulting quotient, as calculated in Section B.2.a.i. above, shall be multiplied by the hospital's total operating cost per diem, as calculated in Section A.2.a.i.B).

==07/95 iii. The capital related cost per diem, as calculated in Section A.2.a.ii., is then added to the resulting product calculated in Section B.2.a.ii. above, subject to the inflation adjustment described in Section A.2.b.i.

10/93 iv. Subject to the provisions of Section B.2.a.v. and B.2.a.vi. below, the final distinct part unit payment rate shall be the lower of:

10/93 A) The result of the calculations described in Sections B.2.a.i. through B.2.a.ii. above; or

10/93 B) The hospital's alternate cost per diem rate, as calculated in Section B.1. above.

10/93 v. In no case shall the hospital's final distinct part unit payment rate be greater than three standard deviations above the mean distinct part unit payment rate.

10/93 vi. In the case of a new distinct part unit for which the Department has insufficient adjudicated claims history data available, the Department shall utilize the average payment rate calculated under this Section for like distinct part units.

==07/95 b. For admissions occurring within a rate period described in Section B.2.b. of Chapter XVI., the distinct part unit payment rate shall be the distinct part unit payment rate in effect on June 30, 1993, as calculated under Section B.2.a. above, updated to the midpoint of the current rate period, using the TEFRA price inflation factor.

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3. In the case of a new hospital (not previously owned or operated), a hospital has significantly changed its case-mix profile (e.g., a general acute care hospital changing its case-mix to reflect a predominance of long term care patients), or an out-of-state non cost-reporting hospital, reimbursement for inpatient services shall be as follows:

10/93

a. For general acute care hospitals, reimbursement for inpatient services shall be at the average payment rate calculated under Section B.1. or B.2. above for those hospitals reimbursed under the DRG PPS.

b. For psychiatric hospitals, as defined in Section C.1. of Chapter II., reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section A.2. of this Chapter for those hospitals defined in Section C.1. of Chapter II.

c. For rehabilitation hospitals, as defined in Section C.2. of Chapter II., reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section A.2. of this Chapter for those hospitals defined in Section C.2. of Chapter II.

d. For long term stay hospitals, as defined in Section C.4. of Chapter II., reimbursement for inpatient services shall be at the average rate calculated under Section A.2. of this Chapter for those hospitals defined in Section C.4. of Chapter II.

e. For children's hospitals, as defined in Section C.3. of Chapter II., reimbursement for inpatient services shall be at the average rate calculated under Section B.1. of this Chapter for those hospitals defined in Section C.3 of Chapter II.

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09/91 C. Children's Hospitals

10/93 1. Initial Rate Period

10/93 a. For purposes of reimbursement, all children's hospitals, as defined in Section C.3. of Chapter II., are grouped into one peer group.

10/93 b. Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.

10/92 c. These base year costs shall be updated, trended forward, from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set according to the methodology of the national total hospital market basket price proxies, (DRI).

10/92 d. The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as its final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.

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10/92 2. Subsequent Rate Periods

==07/95 For the rate period beginning on October 1, 1992, as described in Section B.2.a. of Chapter XVI., and for subsequent rate periods, as described in Section B.2.b. of Chapter XVI., the initial rate, as calculated under Section C.1. above, shall be updated from the midpoint of the base cost reporting period to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

09/91 D. Hospitals Reimbursed Under Special Arrangements

10/93 Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in Sections H. through J. of Chapter VIII.

==07/95 E. Applicable adjustments for disproportionate share and various specific inpatient payment adjustments as specified in Chapter VI.

==07/95 The criteria and methodology for making applicable disproportionate share and various specific inpatient payment adjustments to hospitals which are exempt from the DRG PPS shall be in accordance with Chapter VI. and Chapter XV.

==07/95 F. Outlier Adjustments for Exceptionally Costly Stays

==07/95 1. Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Chapter X.

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==07/95 2. For inpatient services provided on or after October 1, 1992, the Department shall make outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for infants who have not attained the age of one (1) year, and to children who have not attained the age of six (6) years, and who receive such services in a disproportionate share hospital described in Section C.1.a. through C.1.e. of Chapter VI. The Department is not required to provide outlier adjustments for exceptionally long lengths of stay as there are no durational limits on inpatient stays and the Department reimburses the hospital on a per diem or per day basis regardless of the length of stay as long as such stay was medically necessary. The determination of those services qualified for an outlier adjustment shall be made as follows for services provided on and after October 1, 1992, and for each subsequent rate period, as defined in Section B.2.b. of Chapter XVI., for hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Chapter X.:

10/92 a. The services must have been provided on or after October 1, 1992; and

b. The services must have been provided to:

10/93 i. Children who have not attained the age of six (6) years by hospitals defined by the Department as DSH hospitals under Sections C.1.a. through C.1.e. of Chapter VI.; or

10/93 ii. Infants who have not attained the age of one (1) year by hospitals that do not meet the definition of a DSH hospital under Section C.1.a. through C.1.e. of Chapter VI.

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c. Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:

==07/95

i. Total covered charges (less charges attributable to medical education) equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.

ii. The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.

iii. The product of (ii) above shall be subtracted from the product of (i) above.

iv. The difference of (iii) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.

v. Third party payments (credits) shall be applied to the final payment made on the claim.

10/93 3. Definition of terms related to outlier adjustments are as follows:

10/92 a. "Base fiscal year" means the hospital's fiscal year cost report most recently audited by the Department.

10/92 b. "Cost to Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year.

10/93 c. "Mean total covered charges" means the mean total covered charges (as described in (e) below), for services provided in the most recent state fiscal year for which complete information is available and which have been adjudicated by the Department, as follows: